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It's about you and your health!

Integrated Health Service Plan 2
April 2010 – March 2013

Approved by the Board of Directors
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Ontario

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Acknowledgements

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1. Introduction

The fastest growing community in Canada. A highly diverse population. The highest birthrate in the province. Rapid change with the opening of a new hospital site.

These key features describe the landscape of the Central West Local Health Integration Network (LHIN). It has been three years since the Central West LHIN released the first Integrated Health Service Plan in 2006. In this time, the LHIN has undergone significant change, built strong relationships, and achieved significant milestones.

This document, our second Integrated Health Service Plan ("IHSP2"), examines the Central West LHIN's evolution and progress over the last three years, builds on our 2008 Health System Plan, and describes the actions needed to continue to improve access to integrated, high quality health services in the LHIN.

Local Health Integration Networks

In 2006, under the Local Health System Integration Act, the provincial government established 14 Local Health Integration Networks (LHINs) which were given the authority to plan, coordinate, integrate, fund, and monitor the local health system, comprised of health care providers including community care access centres, community health centres, community mental health and addiction services, community support services, hospitals, and long term care facilities.

In partnership with health service providers and the community, the Central West LHIN has the task of improving the health of residents who live in the local communities of the LHIN's geographic boundaries.

Integrated Health Service Plan 2

The first IHSP was our starting point and focused on planning for three years of the LHIN's operation (2007-2010). This document, the second IHSP, builds on the planning, lessons learned, and successes so far, and will provide direction for the next three years (2010 - 2013). IHSP2 was developed in consultation with health service providers and the community to ensure the unique needs of the communities of the Central West LHIN are met.

This document illustrates the journey we have travelled and reflects the progress made over the last few years. IHSP2 expands on the Central West LHIN's Health System Plan, which laid out a system approach aimed at improving access to a core of local community-based services, supported by a "one hospital system".

A critical part of IHSP2 is the inclusion of realistic, measureable outcomes for the LHIN. Over the next three years, our work will be reviewed and refined on a regular basis to ensure the needs of those that receive health care and those that deliver it are met. It's about you and your health!

2. Summary of the provincial strategic plan and alignment of the IHSP2

Our IHSP2 aligns with the Ministry of Health and Long-Term Care's priorities to promote equitable access to health and health care for all Ontarians. At the same time, the improvement strategies we describe in the following chapters reflect local needs and local strengths.

LHINs have been asked by the Ministry of Health and Long-Term Care to focus on improving access to services in three areas:

- Reducing wait times in Emergency Departments
- Reducing the time patients spend in Alternate Level of Care (ALC) beds in hospitals
- Supporting the roll-out of Ontario's Diabetes Strategy

In addition, LHINs are ready to participate in provincial strategies to improve care for mental health and addictions and build innovative infrastructure through improved information management (eHealth).

Reducing Wait Times in Emergency Departments

Ontarians are entitled to safe, reliable, appropriate, and high-quality care when they visit an Emergency Department. Because reducing wait times in Emergency Departments can significantly improve a patient's acute health care experience, it is one of the Ontario Government's top health care priorities.

To achieve shorter Emergency Department wait times, the LHINs must improve performance across the entire health system.

Under the Ministry's direction, we are working towards achieving provincial targets and publicly reporting our Emergency Department wait times. We are implementing initiatives to improve the capacity within the Emergency Department to care for more patients in a more timely way. We are developing services in the community that will divert individuals seeking primary care in the Emergency Department.

Reducing Time in Alternate Level of Care (ALC) Beds

When patients complete the acute care phase of their treatment in hospital, they may remain in acute care beds while they are waiting to be discharged or transferred. They need services other than acute hospital care, but none is available.

Close to 19% of patients currently in Ontario hospital beds are waiting for an Alternate Level of Care opening, such as a long-term care, rehabilitation care bed, or an array of services in the community. With beds occupied by patients waiting to move elsewhere, a patient in the Emergency Department cannot be admitted, causing a domino effect that leads to longer Emergency Department wait times.

The Central West LHIN is working on a variety of initiatives to help patients get the care they need – whether in a hospital, a long-term care, or rehabilitation care facility, in the community, or at home.

Supporting Ontario's Diabetes Strategy

Ontario's Diabetes Strategy responds to a growing – and expensive – health care challenge. In 2008, about 900,000 Ontarians were living with diabetes (8.8% of the province's population). Treatment for diabetes and related conditions (including heart disease, stroke and kidney disease) currently costs Ontario over $5 billion each year.

The Diabetes Strategy will improve access to prevention programs and team-based care. It includes an online registry that will give patients access to information and educational tools so they can better manage their disease. The registry will also enable health care providers to check patient records, access diagnostic information and send patient alerts. The registry will result in faster diagnosis, better treatment and improved management for Ontarians living with diabetes.

The Central West LHIN resident population is known to have a higher predisposition to diabetes. We are strongly committed to improving access to diabetes care for our local communities by supporting the roll-out of the provincial Diabetes Strategy.

Enhancing Mental Health and Addictions Services

The Ontario Government has announced that it plans to enhance mental health and addictions services. About one in five Ontarians will experience a mental health or addiction problem at some time, and the cost to individuals and society is enormous.

The Minister's Advisory Group on Mental Health and Addictions is laying the foundation for a 10-year strategy to address this important issue. The Central West LHIN will implement the provincial Mental Health and Addictions Strategy locally, helping to create a system that provides everyone who needs care with equitable access to safe, respectful, and effective services.

Building on an eHealth Framework

Ontario's eHealth Strategy supports the province's other strategies. By investing in information technology infrastructure, including the diabetes registry and electronic health records, we can improve patient care and access. The Central West LHIN looks forward to building on eHealth Strategy innovations to enhance system-wide integration and improve our health care system.

A Healthier Central West LHIN

The Ontario Government's strategic directions helped to shape this Integrated Health Service Plan. By aligning local initiatives with provincial priorities, we can improve access to integrated, high quality and sustainable health services within the Central West LHIN.

3. The LHIN's vision for the local health system

The Central West LHIN is passionate about its vision to create "a local health system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren".

Our Vision

Create a local health system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren.

The vision captures the commitment of the Central West LHIN to ensure that the best health care is available to residents of its local communities. The vision, principles, and values of the Central West LHIN are based on feedback from local residents and health service providers, and are aligned with the Ministry of Health and Long-Term Care's vision for the LHINs and Ontario's health care system.

The LHIN's activities are based on the following set of values:

- Person-centred: We advance the public good with purpose and passion. We work with individuals and the community in pursuit of optimum health status. We are deeply committed to meeting the health care needs of our community and we constantly focus on client satisfaction.
- Transparency: We are committed to the highest possible ethical standards, and open and timely sharing of information
- Integrity: In all of our activities we will foster trust by being truthful, empathetic, and consistent.
- Stewardship: In managing all resources to which we have been entrusted, we will seek ways to ensure appropriate use of resources, and act responsibly, taking actions that align with our vision, values, and strategic directions.

Over the last three years these values have guided the way we have conducted activities.

During the development of the first IHSP, we followed five guiding principles for integrated service delivery:

- Equitable access based on patient / client need
- Preservation of patients' / clients' choice
- People-centred, community-focused care that responds to local population health needs
- Measureable, results driven outcomes based on strategic policy formulation, business planning, and information management
- Shared accountability between providers, government, community and citizens

In the first IHSP, the LHIN identified strategies to improve local health services:

Enhanced Integration
Better coordinated and better linked health services including seamless movement across the care continuum.

Increased Capacity
Adequate levels of the right kinds of services and supports at the right time at the right place.

Improved Access
Timelier, easier access to high quality, people-centred services.

Integration

The purpose of The Local Health System Integration Act, 2006 reads "to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks" Integration includes:

- the co-ordination of services and interactions between entities
- the partnering of entities in providing services or in operating
- the transfer, merger or amalgamation of services, operations, or entities
- starting or ceasing providing services
- ceasing to operate or dissolving the operations of an entity.

An integrated health care system is characterized by close working relationships among health service providers providing clients with more timely access to services, less duplication of services, elimination of gaps and fragmentation, and better coordination and transfer between services.

A number of examples of early integration initiatives are highlighted in the achievements of the Central West LHIN found later in this document. As the Central West LHIN has matured over its first years, it better understands the potential and possibilities for ensuring better integrated health services. In the section that lists the actions the LHIN will undertake in partnership with health service providers, a number of these actions outline integration priorities that will transform the local health care system.

Health System Plan

In the Health System Plan, the Central West LHIN laid out a detailed vision and plan for a comprehensive and integrated system of community and hospital-based services.

Based on the key findings from the community engagement, data analysis, and leading practice research, the following mandates for the broader health system, community-based health services, and acute care services were established.

Mandate of the Health System	Mandate of Community-based Health Services	Mandate of Acute Care Health Services
A strong foundation of integrated community-based health services which is fully supported by an acute care system. The health service providers collectively deliver consistent, high-quality services at the most effective location for the citizens of the LHIN.	Community-based health services are the first point of contact for residents of the Central West LHIN. The goal is to provide more services which support health and well-being closer to where people live. Health service providers need to deliver services locally but manage in an integrated regional model.	A fully integrated hospital system, which provides a comprehensive range of services to meet the needs of LHIN residents and support the community-based service providers.

We have a vision for an integrated health system where community-based services become the initial point of access, have the capability to handle non-urgent and semi-urgent needs of the Central West LHIN residents, and are supported by one integrated acute care system.

The Health System Plan identified a set of core services that support service delivery closer to home. These core services can be delivered in a variety of ways and in different locations depending on the local environment and the opportunities that exist. The following services, more fully defined in the Health System Plan, were identified as needing to be available at the local level across all age groups in order to support the vision, principles and strategic goals of the Central West LHIN.

- Promotive
- Preventive
- Curative
- Rehabilitative
- Supportive

The health system will improve access to integrated, high quality health services at all stages of a person's life. Services in the LHIN will be delivered locally but managed within an integrated regional model. In order to achieve improved health outcomes for the local residents, both the community-based and acute care services have to work together. Accountability agreements between the LHIN and local health service providers are essential to the transformation of the health system.

We have a vision for a health system that promotes equity. Meeting the unique needs of the ethno-cultural communities, as well as our Aboriginal and Francophone communities, is a foundation of this IHSP2.

4. Overview of the local health system

Understanding the health needs of the local population and how well the system is meeting those needs lay the foundation for identifying local health system priorities.

The Central West LHIN covers approximately 2,590 square kilometers and includes all of Dufferin County, the northern portion of Peel Region, parts of north-western Toronto and south-west York Region. The geographic area includes a mix of urban, suburban and rural communities.

Growing Population

The Central West LHIN represents 6.1% of Ontario's population. The 2006 census estimated the population to be approximately 739,000.

The LHIN has experienced unprecedented growth. Between 2001 and 2006 the population grew by 19.2%,[1] highest amongst the 14 LHINs and higher than the Ontario growth rate of 6.6%. The population is expected to grow by 25% between 2006 and 2016.

The population of the Central West LHIN is younger compared to the province and the youngest among the 14 LHINs. The median age of the LHIN in 2006 was 34.9 years. The LHIN is expected to experience significant aging of the population in the period between 2006 and 2016.

Central West LHIN women give birth to over 11,000 babies a year, the highest number in all LHINs.

Diversity in the Central West LHIN

The Central West LHIN has a highly ethno-culturally diverse population, with 46% identified as immigrants and over 50% as visible "minorities".

French Language Services

There were 16,135 Francophone residing in the Central West LHIN in 2006.

Aboriginal

There is a very small Aboriginal population (0.6%) compared to the province (2.0%). There are no Aboriginal reserves within the LHIN.

Community	% of population who are visible minorities		% Change
	2001	2006	
Dufferin	3.2%	2.5%	-0.7%
Caledon	5.0%	7.2%	2.2%
Brampton	40.2%	57.0%	16.8%
Malton	68.9%	77.7%	8.8%
Rexdale	58.6%	66.1%	7.5%
Woodbridge	10.0%	16.2%	6.2%
Central West LHIN	38.8%	50.3%	11.5%
Ontario	19.1%	22.8%	3.7%

Sources: Statistics Canada, 2001 and 2006 Census

[1] Statistics Canada. 2006 Census.

Health Status of Residents Reflects High Risks in Some Chronic Illnesses

Central West LHIN residents report very good or excellent physical health overall. Life expectancy is longer in the Central West LHIN (82.3 local to 80.6 years province).

Residents' rating of their own mental health as very good or excellent was 76.3% in 2008, slightly higher than the provincial rate.

The proportion of overweight and obese adults in the LHIN is growing. In 2008, the population in the LHIN that reported being overweight was higher than the province. In 2008, almost one in five youths in the LHIN was overweight or obese.

Prevalence of Chronic Conditions	Central West LHIN		Ontario	
	2007	2008	2007	2008
Arthritis or rheumatism	12.2%	10.9%	16.2%	16.9%
Diabetes	6.8%	8.6%	6.1%	6.2%
Asthma	5.2%	8.6%	8.1%	8.3%
High blood pressure	16.3%	16.3%	16.4%	16.6%

Sources: Canadian Community Health Surveys, 2007, 2008

Hypertension and diabetes is climbing in the LHIN. The percentage of residents with diabetes has increased from 3.9% in 2003 to 8.6% in 2008, higher than the provincial rate of 6.2%.

The percentage of residents reporting high blood pressure increased from 13.3% in 2003 to 16.3% in 2008, slightly lower than the provincial rate of 16.6%.

In 2008, the percentage of residents with arthritis or rheumatism was 10.9%, significantly lower than the province rate of 16.9%.

Reports of asthma from Central West LHIN residents increased from 7.7% in 2003 to 8.6% in 2008, slightly higher than the provincial rate of 8.3%.

Rates of prostate, ovarian and cervical cancer are relatively higher when compared to other LHINs. Most cancer screening rates remain low compared to other LHINs.

Fewest Number of Health Service Providers

The Central West LHIN includes 50 service providers across the health care continuum, the fewest number of service providers among the LHINs. The Central West LHIN ranks the lowest amongst the 14 LHINs in terms of overall per capita health spending.

Community Care Access Centre

The Central West CCAC provided in-home health care services to 21,270 adults, 5,469 children through school programs. Over 4,200 people were placed in long-term care homes in 2008/09.

Home care services used most frequently by Central West LHIN residents in 2008/09 were nursing, occupational therapy, physiotherapy and in-home support services.

The Central West CCAC has established 310-CCAC as an information and referral service which provides one phone number for residents to call to find out what services are available in the LHIN that may meet their needs. Other local information systems are also available, including 211.

Long-Term Care Facilities

The Central West LHIN currently has 3,440 beds for its residents in 24 Long-Term Care facilities in 2008. The number of long stay beds per 1,000 residents aged 75 and older in Central West LHIN was 98.18, which is the third highest among 14 LHINs.

Clinical Utilization

Almost 40% of residents in the Central West LHIN seek their care from providers outside of their LHIN borders. This is the highest proportion among the 14 LHINs.

There are 712 acute care beds, 88 chronic care beds and 52 rehabilitation beds in the Central West LHIN. Since 2006/07 use of local hospital services has increased. This compares to a decrease in the use of services in hospitals across the province.

Emergency Department Volumes Have Increased

Demand for emergency services significantly increased in the Central West LHIN in 2008/09. The opening of the Brampton Civic Hospital altered all rates of hospital services use. Brampton Civic Hospital had the third highest ER volume growth rate in 2008/2009 when compared to 22 peer hospitals. Emergency room wait times have improved for residents of the LHIN, but are not yet as good as the provincial average.

Alternate Level of Care Days

The Central West LHIN has consistently been below the provincial average for Alternate Level of Care (ALC) days, the third lowest over the last two years among LHINs. William Osler Health System experienced 22,658 ALC patient days. Headwaters Health Care Centre, which experienced 1,553 ALC patient days. In the first quarter of 2009/10, the Central West LHIN achieved its target of less than 9% of hospital acute days being ALC days.

Wait Times are Decreasing

Wait times on the government's priority areas continue to decrease. These are measured in days to the first quarter of 2009/10.

	2007/08	2008/09	2009/10
Cancer Surgery	69	64	55
Cataract Surgery	127	208	113
Hip Replacement	291	222	166
Knee Replacement	301	247	168
Diagnostic MRI Scan	125	55	73
Diagnostic CT Scan	38	24	22

High Occurrence of Diabetes

There were 46,082 cases of diabetes in the LHIN (most recent data - 2004/05). This represented one of the highest volumes among the LHINs. However, residents in Central West LHIN are living with this disease and reported the lowest mortality rate per 1,000 Ontarians with diabetes among all the LHINs in these same years.

The occurrence of diabetes per 100 residents in the Central West LHIN increased from 7.7 of 2000/01 to 9.8 of 2004/05. In Ontario the rate was 8.0.

Low Rates of Primary Care Practitioners in the Province

The proportion of adults in the Central West LHIN who reported that they do not have family doctors was 6.7% in 2008, which is slightly lower than the provincial rate of 7.0%.

For every 100,000 people in the Central West LHIN there are approximately 57 general / family physicians in 2007, which was the lowest among 14 LHINs. The LHIN had a higher proportion of residents using walk in clinics than elsewhere in Ontario[2].

Transportation

The area is serviced by an extensive system of highways and roads, but has no comprehensive, single system of public transportation across the LHIN's geography that provides easy access for the population, particularly in less urban areas.

Capital Redevelopment

Headwaters Health Care Centre provides primary and secondary acute care services, and complex continuing care and rehab services. We look to expand Headwaters ambulatory care services and for the potential to locate regional services in the context of integrated regional programming.

Brampton Civic Hospital of the William Osler Health System provides a full range of medical and surgical sub-specialties with an emphasis on regional programs / centres of excellence, providing the highest acuity services with specialized regional and tertiary programs for the entire LHIN. It will support other providers to provide more services closer to home through telemedicine and on-site specialist support. Services will expand to meet local needs as funding to open all the beds of the new hospital is made available.

Etobicoke General Hospital of the William Osler Health System provides secondary acute care services, and complex continuing care and rehab services. We will continue to recognize local expertise and look to redevelop Etobicoke General Hospital as soon as possible by starting with Emergency Department, ICU/CCU, Diagnostic Imaging, Day Surgery / Surgical Suite and Ambulatory Care, and examine the potential to locate regional services in the context of integrated regional programming.

Peel Memorial Health Centre of the William Osler Health System will be a strong multi-purpose health service centre that provides excellence in urgent care, ambulatory care, surgical procedures, and specialty services (geriatrics, woman and children, mental health) focusing on primary care and chronic disease prevention services, and provide inpatient complex continuing care and rehabilitation services.

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[2] Ministry of Health and Long-Term Care. 2008. Primary Care Access Survey Standardized Report.

Achievements

Over the past four years the Central West LHIN Board members and staff have been out at nearly 70 community engagement sessions, all across the LHIN's geography, to engage the residents of the LHIN and discuss the first Integrated Health Services Plan, the Health System Plan, and our Aging at Home strategy. The information gathered at these community engagement sessions has been the foundation of our work.

It is important to recognize the impact of the LHIN on planning of health care services, on enhancing integration, increasing capacity, and improving access. The following provides a list of achievements related to the initial IHSP and implementing the LHIN's Health System Plan, and related to meeting the government's priorities.

Aboriginal Health

- Co-sponsor of the GTA Aboriginal engagement strategy
- Established Aboriginal Community Engagement Coordinator developing local engagement strategy

Back Office Integration

- Completed Back Office Integration Study

Chronic Disease Management and Prevention

- Developed plan for establishing a regional Chronic Kidney Disease program
- Developed local e-health Diabetes Registry model

Diversity

- Established Diversity Core Action Group to work closely with LHIN's diverse communities and health service providers to better understand specific issues and how to address them
- Facilitating the process of integrating cultural diversity into all LHIN priority areas

ER / ALC

- Established Right Health Care Setting Core Action Group
- Met ALC target
- Directed funding to the Central West CCAC to implement Enhanced End of Life Initiative and Short Term Extraordinary Circumstances Initiative
- Established Nurse Practitioner Rapid Response Team
- Established Nurse Led Long Term Care Outreach team
- Implemented Medical Surgical Clinical Decision Unit (CDU)
- Implemented Mental Health Clinical Decision Unit (CDU)
- Established CCAC case manager role in the Brampton Civic Hospital ER
- Implemented Home at Last
- Implemented Wait At Home
- Appointed Critical Care Lead
- Added 2 new critical care beds
- Developed surge capacity plan

French Language Services

- Planning with the Ministry Regional Consultant - French Language Health Services, GTA LHINs and Toronto Region French Language Health Services Planning and Support Committee
- Completed survey of local French language health services
- Coordinating meetings of identified health service provider organizations and representatives of local francophone community

Health Human Resources

- Established the Health Professionals Advisory Committee
- Working with HealthForceOntario Partnership Coordinator to recruit physicians to LHIN
- Review of nursing workload and scope underway

Information Management

- Created E-health Strategy
- Appointed local E-Health Lead
- Implemented one-mail / one-network
- Completed diabetes readiness assessment
- Established the local e-Health project management office
- Incorporated physician engagement on the physician e-health strategy
- Established the physician steering group to develop an Electronic Medical Record

Integrated Regional Programs

- Established clinical priority areas and begun planning and development of integrated regional programs within the Central West LHIN
  - Cancer (Cancer lead appointed)
  - Maternal - Newborn
  - Paediatrics
  - Nephrology
  - Trauma
  - Cardiac-Vascular
  - Mental Health and Addictions
  - Orthopaedics
  - Geriatrics

Maternal / Child Services

- Established Maternal / Child Core Action Group
- Appointed and funded the Central West LHIN Maternal / Child Lead
- Facilitated Memorandum of Understanding between William Osler Health System and Headwaters Health Centre for obstetrical services
- Established Brampton Civic Hospital as the Regional Perinatal and Children's Health Centre
- Identified funding for cross-jurisdictional children's initiative
- Identified clinical priorities
  - Antenatal services - Breastfeeding - Obesity - Speech and language services
  - Maternal mental health - Medically complex / fragile children
- Collaborating with Public Health and family physicians to address local needs
  Involved at various provincial tables

Mental Health and Addiction Services

- Established Mental Health and Addictions Core Action Group
- Developed service agreement template for use across health service providers
- Memorandum of Understanding for William Osler Health System to support care and treatment for individuals with mental health issues arriving at Headwaters Health Care Centre Emergency Department
- Provided funding for supportive housing in Dufferin and Malton
- Established the Dufferin Integration Partnership Solution
- Funded South Asian addiction services
- Funded seniors mental health case management services in Dufferin County
- Provided funding for cross-sectoral mental health and addictions training for providers of services to seniors
- Completed Malton Connects plan to determine needs to improve access for local residents
- Implemented Seniors Mental Health Intensive Case Management and Outreach Service
- Established the Concurrent Disorders Network to enhance system-wide capacity and implement care pathways

Palliative Services

- Established the Palliative Care Network with CCAC, local hospitals and community providers developing hospital / community-based model based on best practices
- Supported the development of Bethell House operated by Hospice Caledon

Primary Care

- Engaged local physicians, the Ontario Medical Association, and Ontario College of Physicians and Surgeons to develop a physician engagement strategy and for input on LHIN initiatives
- Developed 4 Family Health Teams, provided input on next wave
- Established Bramalea Community Health Centre and developing Malton Satellite
- Developing Rexdale Community Health Centre's 2 satellites Jamestown and Albion/Kipling

Services for Seniors

- Established the Seniors Core Action Group
- Investing $12.7M of Aging at Home funding in 35 initiatives including: Home at Last, Nurse Practitioner Outreach to LTC residents, Telecheck, volunteer programs, homemaking and maintenance programs, ethno-cultural seniors services, home visiting, seniors community mental health, supportive living, adult day programs and transportation services
- Working with hospitals and the CCAC to establish a regional geriatric program
- Supported LTC Home Renewal Strategy applications

Rehabilitation Services

- Active rehabilitation program is now concentrated in the newly opened 32 bed unit at Brampton Civic Hospital
- Rehabilitation study completed (hip and knee, stroke, injury/accident, acquired brain injury) providing a baseline of existing rehabilitation services and performance and direction for future program development.

Governance-to-Governance

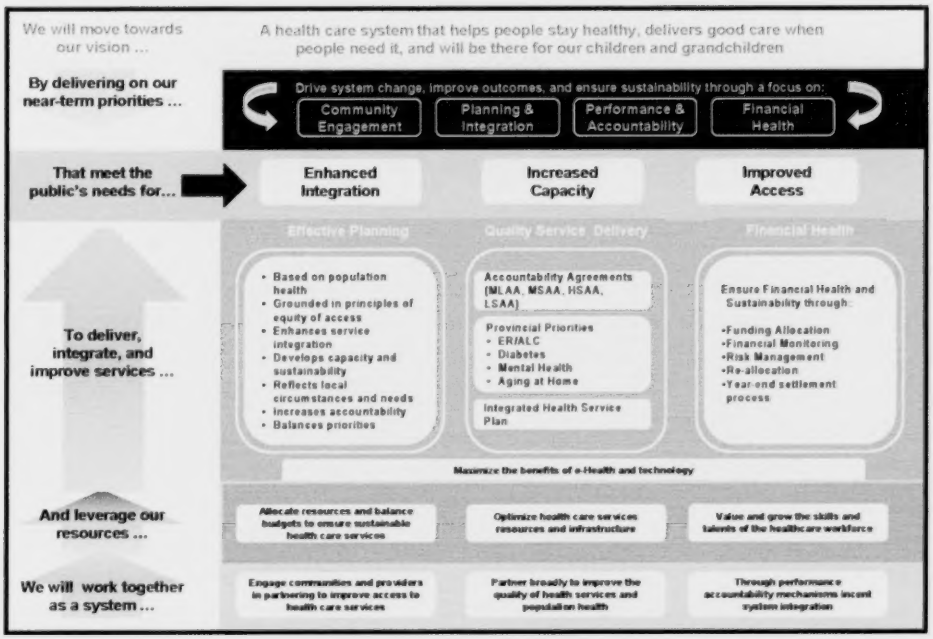
The Central West LHIN has taken a lead in the development of the "Governance-to-Governance" initiative which has brought together Board members of the LHIN and Board members of the many health service provider organizations in the LHIN to develop rapport, learn about the role of the LHIN and its activities and the role of each health service provider, raise the bar on governance leading practices, and explore the role of governance in promoting and implementing the transformation agenda.

The LHIN has created the 'Governing Together - Our Health System' portal accessible to Board members of the LHIN and from across health service providers to share information and best practices.

5. Framework for planning

Strategy Map

The Central West LHIN health strategy map illustrates how we work to achieve our vision for the local health system and how strategic transformation of the health system will be achieved.


We will move towards our vision ...
A health care system that helps people stay healthy, delivers good care when people need it, and will be there for our children and grandchildren
By delivering on our near-term priorities ...
Drive system change, improve outcomes, and ensure sustainability through a focus on:
Community Engagement
Planning & Integration
Performance & Accountability
Financial Health
That meet the public's needs for...
Enhanced Integration
Increased Capacity
Improved Access
Effective Planning
Quality Service Delivery
Financial Health
• Based on population health
• Grounded in principles of equity of access
• Enhances service integration
• Develops capacity and sustainability
• Reflects local circumstances and needs
• Increases accountability
• Balances priorities
Accountability Agreements (MLAA, MSAA, HSAA, LSAA)
Provincial Priorities
• ER/ALC
• Diabetes
• Mental Health
• Aging at Home
Integrated Health Service Plan
Ensure Financial Health and Sustainability through:
•Funding Allocation
•Financial Monitoring
•Risk Management
•Re-allocation
•Year-end settlement process
To deliver, integrate, and improve services ...
Maximize the benefits of e-Health and technology
And leverage our resources ...
Allocate resources and balance budgets to ensure sustainable health care services
Optimize health care services resources and infrastructure
Value and grow the skills and talents of the healthcare workforce
We will work together as a system ...
Engage communities and providers in partnering to improve access to health care services
Partner broadly to improve the quality of health services and population health
Through performance accountability mechanisms incent system integration

Priority Setting

The Central West LHIN believes in collaboration, partnership, and shared accountability. Health service providers and community partners along with LHIN's Board of Directors and staff have a vital role in the improvement of local health services. Partnership across the continuum of care is essential to transforming the health system. Over the last three years we have undertaken considerable planning activities and are eliciting real, tangible results. The focus of the next three years is to continue to push the boundaries of the status quo to transform the local health system.

Accountability agreements, including the Central West LHIN's accountability agreement with the Ministry of Health and Long-Term Care (MLAA), and individual accountability agreements with health service providers are fundamental to creating change.

The publication ***High Performing Healthcare Systems: Delivering Quality by Design*** by the G. Ross Baker of the University of Toronto describes the features of a high performing health system. We have referenced these in establishing our integration priorities to move forward.

Features of high performing health care systems include:

- Focus on patients / clients first
- Quality
- Improving outcomes
- Integration of services across levels of care, sites, and disciplines
- Leadership
- Information technology and meaningful measurement
- Engaged physicians and staff workforce
- Strategic alignment of aims, measures and activities
- Accountability.

Client focus is at the centre of all of the LHIN's activities, from community engagement to client centred care. Performance measurement and outcome improvement are the key components of the LHIN's accountability structures.

The Central West LHIN piloted a decision-setting framework to evaluate Aging at Home initiatives. The LHIN will apply the framework to other priority setting and funding decisions. Criteria are based on the following key concepts:

- Senior / family centred
- Population health focus
- Evidence-based
- Promotes integration
- Improves equity of access
- Supports sustainability
- Demonstrates partnership
- Advances the goals of the Central West LHIN IHSP.

Additionally, we are improving our understanding of the Institute for Healthcare Improvement's (IHI) Triple Aim framework and how it might be applied to our planning. In this methodology there are three important objectives that need to be considered:

- Improve the health of the population
- Enhance the client experience of care (quality, access)
- Control the cost of care.

There are similarities across these models or frameworks for developing a better system of health services. We will be informed by and employ evidence-based and practical methodologies along with what we hear from our stakeholders and our analysis of data to define actionable, realistic priorities to improve the health of our community.

6. Priorities and strategic directions for the local health system, including specific goals and rationale

The Central West LHIN has identified a series of priorities for action over the next three years. These priorities are aligned with the Ministry of Health and Long-Term Care priorities and continue work identified locally in our first Integrated Health Services Plan and in the Health System Plan.

The local health care system will be tailored to the needs of the residents of the LHIN. It needs to be built on a strong system of primary care. Services should be as close to home as possible. Working together, with health service providers, we will drive health system transformation.

Our priorities will increase integration. It is our vision that the Central West LHIN residents will access more standardized, consistent, best practice care. This will mean the right care, at the right time, in the right place, by the right provider. Our priorities are aimed at increasing access to quality services across the continuum of care.

Our priorities are built on the concept of health equity. All individuals in the LHIN should have access to quality services that recognize their unique needs. This work addresses the specific and unique population health needs heard in our community engagement sessions over the past four years.

In the following section we outline our priorities for change based on the provincial priorities for change and our Health System Plan. Each priority is introduced with a broad vision statement and includes key outcome measures.

Meeting Provincial Priorities

ER / ALC

We have a vision for an emergency system that delivers high quality patient-centred care that meets the urgent needs of the community and that reduces wait times in the emergency department.

Long waits for patients in emergency departments are a symptom of a health care system that needs improvement. Reducing waits is fundamental to the LHIN's work with health service providers to ensure patients obtain the right type of service in the right place at the right time. This includes decreasing the number of days patients are staying in hospital when they should be receiving care and treatment in another setting.

Improving emergency department performance and decreasing ALC days will enable our hospitals to optimize resources to address the needs of the fast growing population.

Our integration priorities tie directly into our commitment to reduce Emergency Department wait times and decrease Alternate Level of Care days by improving efficiencies and utilization. ER / ALC issues cannot be addressed by focusing on the Emergency Department alone. It requires a system approach, within individual organizations, and across health service providers.

The Central West LHIN's Right Health Care Setting Action Group, comprised of hospital, CCAC, community service health providers, and the LHIN, has been charged with focusing on the issues facing the Emergency Department and the number of ALC patients occupying hospital beds.

Key outcomes will be the reduction in ER wait times and ALC days to meet, or exceed, LHIN accountability agreement targets.

Diabetes

We have a vision for a system of services that improves the lives of people living with, or at risk of, chronic diseases. Our initial work with diabetes will establish the platform for excellence in the prevention and management of chronic diseases.

The goal of chronic disease prevention and management (CDPM) is to educate patients on self-management and to treat patients sooner and closer to home.

The province is developing patient-focused models of care that will provide education to avoid the onset of disease, by early diagnosis of diabetes, effective self-management education for patients, on-going monitoring, and the rapid treatment of complications. How these models of care will be developed and implemented locally is a key priority for the Central West LHIN.

Diabetes is of particular importance to the Central West LHIN since it has one of the highest prevalence rates of diabetes amongst the LHINs, and it has increased steadily from 7.7 per 100 residents in 2000/01 to 9.8 of 2004/05. Additionally, the prevalence of end stage renal disease (often the result of complications with advanced diabetes) has increased by 55% from 1998 to 2007 in the Central West LHIN population. There is evidence that suggests a predisposition to diabetes in the high immigrant and ethno-culturally diverse population of the Central West LHIN.

We look to establish a system of care that promotes education, prevention, and wellness to empower individuals to actively self-manage their chronic diseases in partnership with their primary care providers, addresses complications and co-morbidities, and is tailored to meet the needs of the LHIN's ethno-cultural communities.

Key outcomes will be an increase in the number of clients enrolled in diabetes education teams and an improvement in clinical outcome, based on clinical guidelines.

Mental Health and Addictions

We have a vision of an expanded community-based, consumer-centred, mental health and addictions services system, designed to improve the lives of people living with mental health and addictions and which meet their individual health needs and circumstances.

The Ministry of Health and Long-Term Care is in the process of developing a ten-year mental health and addictions strategy to address factors that contribute to mental illness and addictions and improve the lives of those living with mental illness and addictions.

Recent studies done in Dufferin County and in the Malton community reported the lack of community services and supports for individuals requiring mental health and addiction services. Per capita spending on community mental health and addictions in Central West LHIN has been among the lowest in the province.

Services will be grounded in need and in recovery. Individuals and their caregivers will know how and when to access a wide range of integrated services across the continuum that supports those living with mental illness and addictions. Our work will reduce stigma and its impact on individuals with mental health and addiction issues. We look for LHIN residents with mental illness and addictions to be able to make their own decisions about their care, treatment and goals for recovery, as well as to self-monitor their condition. The preferred location of these services will be in the community.

Although jurisdictional issues may influence the LHIN's role in developing mental health services for child and youth, the LHIN will continue to work across providers to help address the need for improved access to these vital services.

Key outcomes will reduced rates of inappropriate emergency room visits and rates of hospitalization for mental health and addiction related conditions.

Information Management

We have a vision of a system that leverages information management to link health service providers, better manage patient / client care, enhance decision making, and empowers individuals to self-manage chronic illnesses.

Central West LHIN wide information integration is essential to improving the patient experience and connecting providers and to improve communications, support decision making, reduce errors, and facilitate patient self management of chronic illnesses.

The Ministry of Health and Long-Term Care has made a commitment to implement the Diabetes Registry and Electronic Health Record across the province. The LHINs will drive the implementation of these priorities by leveraging existing assets and capabilities. Participation in the GTA HIAL and other projects offers significant partnering opportunities for health service providers. In addition, innovative eHealth solutions must be found to integrate the information of community agencies that have limited information management and information technology infrastructure in place.

Key outcomes will be to implement a number of provincial and local initiatives to improve and link information.

Aboriginal Health

We have a vision of Aboriginal health services that are built on what we have heard from our Aboriginal community about traditional and holistic views of health.

The Aboriginal community faces health challenges. In keeping with Ontario's Aboriginal Health and Wellness Strategy, the LHIN will identify needs and gaps in services and health for the local Aboriginal community and work to improve access to health services that address the unique needs of the Aboriginal community. This vision will be illuminated through dialogue with members of the local Aboriginal community.

A key outcome will be an increase in access by members of the Aboriginal community to services developed to meet their specific needs.

French Language Services

We have a vision that members of the francophone community have access to an array of health services in French.

Three cities within the Central West LHIN are designated under the French Languages Services Act – Toronto (Rexdale), Mississauga (Malton) and Brampton. This legislation ensures francophones access to services free of language barriers. The Province has updated the definition of francophone. With this new, more inclusive definition, the number of francophones in the Central West LHIN is approximately 16,150.

The quality of the patient experience for the francophone community will be enhanced when its members can receive health care services in French. The Central West LHIN and health service providers will meet the obligations of provincial legislation.

Key outcome will be an increase in the number of health services available to members of the francophone community provided in French.

Implementing the Health System Plan

Primary Health Care

We have a vision of expanded team-based primary health care that is there for all residents, is built upon the needs of the LHIN's diverse communities, is connected through information technology, and is linked to community and acute care services.

Primary care is the appropriate first point of contact for health services in an integrated model of care. A well developed primary care system is foundational to health system transformation. A strong primary care system will have a positive impact on improving access and quality of care, enhancing the patient's experience, and reduce emergency department volumes and wait times.

Primary care may be delivered by a family physician, or other health care practitioners, and there are a number of successful practices in operations within the Central West LHIN that may serve as models.

Key outcomes will be an increase in the number of primary care services and an Increase the number of residents with a primary care physician

Integrated Regional Programs

We have a vision of comprehensive, integrated LHIN-wide programs that create a critical mass of high quality treatment and care across the continuum to meet local needs as close to home as possible.

We will focus on implementing fully integrated services across the continuum of care for specific populations, such as children, woman, and seniors, and for individuals with particular diseases, such as cancer and cardiovascular diseases.

The Central West LHIN will work with health service providers to "repatriate" its residents, that is, to improve the possibility for the local community to receive health care services within the Central West LHIN.

Key outcomes will be reductions in waiting times for provincial priority areas (cancer, cataract, hip, knees, MRI, CT) and improved local access to integrated regional program services (improved localization index across service areas).

The following regional programs will be established over the next three years.

Cancer

We have a vision of a local regional cancer program within the Central West LHIN addressing the needs of the local community by developing core cancer services within local health service providers. The integrated regional cancer program will establish both screening and treatment at sites across the LHIN.

Historically and currently, rates of cancer screening have been relatively low compared to the provincial averages. Rates for pap tests (67.9%) and mammograms (60.3%) are lower than the provincial rates.

The average wait time in the Central West LHIN to receive cancer surgery was 55 days, which is slightly lower than the provincial average. The average wait time to receive cancer treatment in the Central West LHIN was 84 days in 2008, which is higher than the provincial average (72 days), and increased from 63 days in 2007.

Cardiovascular

We have a vision for a regional cardiovascular program which will be built from the ground up to meet the needs of local residents, with particular attention to the large South Asian population.

Although the demand for cardiovascular services is high, the Central West LHIN currently does not provide the full breadth of services to meet this demand (e.g., angioplasty and cardiac bypass surgery). Thus the development of services locally will be a focus for the coming three years.

As with diabetes, the ethno-culturally diverse population in the Central West LHIN appears to have a high incidence of cardiovascular disease.

Musculoskeletal

We have a vision for a full spectrum of musculoskeletal services that is close to home and well prepared to handle trauma and surgery.

Musculoskeletal refers to the full spectrum of care for bone, muscle, cartilage and tendons. The aging population will increase the need for hip and knee replacements as well as services associated with falls. Rehabilitation is an important component in the treatment of patients who have received surgery or who have been injured so that they can return to their level of functioning prior to receiving services.

Palliative Care

We have a vision for a palliative care system that is respectful of individual and caregiver needs and preferences.

Everyone should be entitled to die in comfort, with access to compassionate, quality, and respectful care. The growing demand for palliative care services in a hospice environment is being addressed by new services developing in the Central West LHIN.

Rehabilitation

We have a vision for a rehabilitation system that is coordinated, easy to navigate and provides timely treatment aimed at returning people to their abilities prior to receiving treatment and care. There will be a focus on establishing specific rehabilitation services for musculoskeletal, stroke, cardiovascular, and trauma.

Over the last three years, William Osler Health System has undergone program consolidation and has increased the number of rehabilitation beds. These beds are at Brampton Civic Hospital. There remains a significant gap in rehabilitation services in the Central West LHIN. The proportion of local residents seeking rehabilitation services outside of the LHIN has increased significantly from 7.73% in 2005 to 23.73% in 2007.

Services for Seniors

We have a vision for a "seniors-friendly" health care system built on the needs of seniors and their caregivers, that is coordinated and easy to navigate, and that provides a broad range of quality and timely services across the continuum. These services will maintain seniors' independence in the community and be close to home.

The Aging at Home Strategy is focused on assisting seniors to stay healthy and live independently. The Province's Long-Term Care Home Renewal Strategy will redevelop Long-Term Care facilities.

Although the current population of the Central West LHIN is relatively young, the number of elderly is projected to increase dramatically in the coming years. The seniors population is expected to grow 54.3% by 2016 in Central West LHIN. This is the largest percentage growth in all of the LHINs.

The Central West LHIN aims to ensure health care services, both in the community and in hospitals, are senior-friendly. Furthermore, given the high percentage of residents within the LHIN who are from ethno-culturally diverse communities, senior-friendly health services for these individuals will require new and innovative approaches.

Providing care to frail elderly is one of the biggest challenges facing healthcare. Studies have attributed a significant proportion (almost 62%) of injury-related hospitalizations amongst the elderly to falls[3]. Programs targeted at reducing falls could have a significant impact on the health of seniors.

Services for Women and Children

We have a vision for a system of women and children's care, which is family-based, educates before birth, provides supports during delivery and infancy, promotes health promotion and prevention, is there for children as they grow, and meets the diverse needs of the ethno-cultural communities.

There are significant issues and needs for not only mothers and newborns, but more broadly for women and children. The Central West LHIN has broadened its previous integration priority from "Maternal and Child" to "Women and Children" services.

The Central West LHIN is home to the highest number of births in the province. In 2007/08, 11,523 women residing in the Central West LHIN gave birth. Approximately 40% of these women gave birth in hospitals outside the LHIN. Women in the Central West LHIN have poor access to prenatal care. There is a high incidence of low birth weight babies. This is likely to create health implications as these children grow.

There are increasing rates of obesity, increasing the chance of chronic illnesses, like diabetes. The Paediatric Complex Care Expert Panel identified three groups of children that require special attention - those with complex obesity, those with complex mental health issues, and those that are medically fragile. William Osler Health System has the highest paediatric inpatient volumes than any other GTA hospital.

The Central West LHIN has two hospital sites providing level 2 maternity services (services for women and babies with health problems) and one hospital site providing level 1 maternity services (for women with low risk pregnancies). At the provincial level, several strategies have been launched, and councils and committees established to address the health issues of women and children. The Central West LHIN has aligned its priorities as an extension of this provincial focus.

Diversity and Equity

We have a vision for a health system that values ethno-cultural diversity and works to improve access for all residents of the Central West LHIN to culturally competent health care services.

The Central West LHIN is one of the most ethno-culturally diverse regions in Ontario. The majority of the population is a visible "minority". Over 45% are immigrants. This rich diversity requires health services designed to be sensitive to language barriers, respect cultural beliefs, and targeted to prevent and treat diseases frequently seen in these populations.

3 "Report on Seniors' falls in Canada", Minister of Public Works and Government Services Canada, 2005.

Health services need to promote health equity to all residents of the LHIN regardless of age, gender, ethnicity, socio-demographic characteristics, education, religion, language, sexual orientation, or any other factors. The LHIN is working in partnership with local health service providers to improve access to culturally competent health care services.

A key outcome will be an increase in the number of culturally competent health service providers.

Health Human Resources

We have a vision of expanded inter-professional collaboration and education, and an increase in the number of health human resources in the LHIN that reflect the needs and diversity of the LHIN communities.

The Central West LHIN has had the highest population growth in the province and is projected to continue to grow at a substantial rate over the next few years. The Central West LHIN has the fewest number of health service professionals, especially physicians. Localization rates suggest that a significant proportion of Central West LHIN residents are receiving primary care services in neighbouring LHINs. An increase in the health human resources, as well as a strong focus on inter-professional collaboration, will improve access to needed health services in our LHIN.

Key outcomes will be higher per capita rates for health professionals and an increased number of inter-professional collaborations and working arrangements.

Back Office Services

We have a vision of administrative and support services focused on effectiveness and efficiency by improving value, service quality, risk management, and business controls.

Back office integration initiatives focus on service improvements, the avoidance of additional future costs, the reduction of unnecessary duplication, and the application of savings for reinvestment in improved / expanded clinical and / or administrative services. Based on the review conducted in the LHIN to identify Back Office options, the Central West LHIN has opportunities to improve risk management, service quality and business controls. Sharing resources and collaboration will result in more consistent business processes, especially among smaller health service providers, which should result in improved efficiencies. Shared Services West is a local organization that presents potential to support this initiative.

Key outcome will be higher rates of use of group purchasing initiatives by health service providers and an increase in the number of collaborations among health service providers that enhance capacity within back office functions.

7. How success will be demonstrated / measured

It will be critical to demonstrate success through monitoring and measuring key indicators linked to our integration priorities, directions, and enablers. The following reflects some measures of performance being considered:

Meeting Government Priorities		
Key Priorities	**Actions**	**Performance Measures**
ER / ALC **We have a vision for an emergency system that delivers high quality patient-centred care that meets the urgent needs of the community and that reduces wait times in the emergency department.**	▪ Be in the top quartile among the LHINs in ER/ALC performance ▪ Utilize evidence-based practices across ER / ALC / Wait Times / Critical Care / Trauma for optimal utilization to address capacity issues ▪ Develop new Family Health Teams (Wave 4) ▪ Establish two Community Health Centre satellites through the Rexdale CHC ▪ Establish the Malton satellite of the Bramalea CHC ▪ Build integrated coordinated services for ER / ALC patients through the Central West CCAC ▪ Implement ED pay for results ▪ Improve access through hospital patient flow redesign initiatives ▪ Invest 3rd year Aging at Home funding to impact on ER wait times and ALC days ▪ Complete plans and begin development of the Peel Memorial site urgent care services to relieve pressure on the BCH emergency department	***Key outcomes will be reductions in ER/ ALC volumes and wait times to meet, or exceed, accountability agreement targets, including:*** • Reductions in ER wait times, length of stay for high acuity patients in the ER to meet Ministry LHIN accountability agreement target • Reduction in percentage of ALC days attributed to patients waiting while non-acute care resources (e.g., LTC bed, home care services) are found • Meet Ministry LHIN accountability agreement target
Diabetes **We have a vision for a system of services that improves the lives of people living with, or at risk of, chronic diseases. Our initial work with diabetes will establish the platform for excellence in the prevention and management of chronic diseases.**	▪ Implement the local diabetes registry ▪ Implement new Diabetes Education Teams in targeted communities, with 3 in 2010/11 to o Improve health status o Speed of assessment o Access to treatment ▪ Implement a collaborative approach with health service providers and public health to ensure initiatives are complementary for obesity, diabetes and youth, to align LHIN initiatives to enhance impact and improve health outcomes ▪ Establish regional Chronic Kidney Disease program based on best practices with hospitals and guidance from the Ontario Renal Network	***Key outcomes will be an increase in the number of clients enrolled in diabetes education teams and an improvement in clinical outcomes including:*** • For diabetes, improvement in clinical outcome measures based on clinical guidelines • Reduced rates of childhood obesity

Key Priorities	Actions	Performance Measures
Mental Health and Addictions **We have a vision of an expanded community-based, consumer-centred, mental health and addictions services system, designed to improve the lives of people living with mental health and addictions and which meet their individual health needs and circumstances.**	▪ Facilitate local implementation of the province's 10 Year Mental Health and Addictions strategic plan ▪ Prioritize ambulatory mental health and addictions patient services in planning for the future Peel Memorial campus ▪ Increase the number of supportive housing units ▪ Support consumer driven initiatives that support mental health and addictions clients in the community through the Consumer Network ▪ Implement the integrated assessment record based upon learnings from the local pilot ▪ Support cross-sectoral mental health and addictions training for providers ▪ Improve access to services in Dufferin based on the Dufferin Integration Partnership Solution ▪ Improve access to mental health and addiction services for residents of Malton by taking action on the Malton Connect Plan ▪ Undertake local integrated mental health and addiction system plans in the communities of Caledon, Rexdale and Brampton ▪ Facilitate implementation of dual diagnosis guidelines ▪ Determine the potential for a role for the Central West CCAC in overall system navigation	***Key outcomes will be the reduction in rates of inappropriate emergency room visits and rates of hospitalization for mental health and addiction related conditions including:*** • Reduced number of ALC days • Reduced number of inappropriate readmissions within 60 days of inpatient discharge
Information Management **We have a vision of a system that leverages Information management to link health service providers, better manage patient care, enhance decision making, and empowers patients to self-manage chronic illnesses.**	▪ Create a Regional Privacy Model ▪ Collaborate with other LHINs where opportunities ▪ Implement the Diabetes Registry ▪ Implement the ED / CCAC e-solution ▪ Implement an e-Referral Solution ▪ Continue to implement the Wait Times initiatives ▪ Implement the Physician e-Health strategy ▪ Implement GTA Connex ▪ Implement the Provider (CSS) Portal ▪ Continue with GTA West PACS ▪ Implement the CCIM initiatives ▪ Implement the Ontario Laboratory Information System (OLIS) ▪ Require each health service provider to develop an organizational Information Management strategy plan to share with the LHIN and other health service providers	***Key outcomes will be to implement a number of provincial and local initiatives to improve and link information, including:*** ▪ Increase the number of LHIN physician practices which are on EMR
Aboriginal Health **We have a vision for Aboriginal health services that are built on what we have heard from our Aboriginal community about their traditional and holistic views of health.**	▪ Establish a Aboriginal community engagement strategy to conduct a needs and gaps analysis of services for the Aboriginal community and to develop a framework for addressing the Aboriginal community's health needs	***Key outcome will be an increase in access by members of the Aboriginal community to services developed to meet their specific needs, including:*** ▪ Increase in health services available to members of the local Aboriginal community tailored to the needs of the Aboriginal community.

Key Priorities	Actions	Performance Measures
French Language Services **We have a vision that members of the francophone community have access to an array of health services in French.**	▪ Initiate francophone Community Engagement strategy ▪ Use accountability agreements to ensure "identified" health service providers comply with the French Language Services Act ▪ William Osler Health System will develop a French Language Services Plan ▪ Ensure the Bramalea Community Health Centre provides access to French language health services by use of the accountability agreement ▪ Promote linkages amongst health service providers to submit proposal for francophone seniors programs	***Key outcome will be an increase in access to health services in French, including:*** ▪ Increase in the number of health services available to members of the francophone community provided in French
Implementing the Health System Plan		
Primary Care **We have a vision of expanded team-based primary health care that is there for all residents, is built upon the needs of the LHIN's diverse communities, is connected through information technology, and is linked to community and acute care services.**	▪ Establish a local health services planning group in Bolton to address the gaps in primary health care services and develop the Health and Care Centre model for local implementation ▪ Target two additional Health and Care Centres in other Central West LHIN communities (one in Dufferin County, one in Region of Peel) ▪ Plan for an academic Family Health Team at the Peel Memorial site ▪ Establish a Nurse Practitioner clinic to improve capacity and access to primary care services ▪ Create CCAC nursing clinics to improve access ▪ Work with the HealthForceOntario Partnership Coordinator to recruit and retain physicians ▪ Continue to work with the physician search groups in Caledon, Orangeville, Shelburne	***Key outcome will be higher utilization of primary care services by local residents as an entry point into the health care system, including:*** ▪ Increase in the number of primary care services ▪ Increase in the number of Central West LHIN residents with a primary care physician
Integrated Regional Programs **We have a vision of comprehensive, integrated LHIN-wide programs that create a critical mass of high quality treatment and care across the continuum to meet local needs as close to home as possible.**	▪ Implement fully integrated services across the continuum of care for specific populations, such as children, woman, and seniors, and for individuals with particular diseases, such as cancer and cardiovascular diseases ▪ Implement prevention and wellness, leading with education to support self management ▪ Tailor care to the needs of each individual, across ethno-cultural communities, and as close to home as possible	***Key outcomes will be improved rates of local utilization across all integrated regional programs, including:*** • Decrease wait times in provincial priority areas to provincial targets • Increased local utilization (localization index) for integrated regional programs • Reductions in ALC days
Cancer	– Expand programmatic campuses of the Regional Cancer Program within the Central West LHIN to include the full continuum of care – Establish approaches to cancer screening that are culturally appropriate	– Higher cancer screening rates (mammography, Pap screens, colonoscopies) – Increased inventory of local cancer services

Key Priorities	Actions	Performance Measures
Cardiovascular	– Build a stroke system with the Central West LHIN that reflects the provincial stroke strategy – Work with internal and external Central West LHIN partners to build a full spectrum of cardiovascular services – Create and execute a strategy for WOHS to develop cardiac services with expertise on treatment and care for South Asian community – Support development of local Percutaneous Coronary Intervention (PCI) program	– Establish baseline targets for performance for local stroke services – Increased inventory of local cardiovascular services
Musculoskeletal	– Create a strategic plan for the establishment of an integrated regional program across hospital and community providers based on best practices – Implement LHIN-wide falls prevention program linked with the Regional Geriatric Service	– Increased inventory of musculoskeletal services – Reduced number of days in hospital due to falls
Palliative Care	– Establish an accessible, full-continuum, comprehensive, integrated community and hospice-based system of palliative services to meet the needs of individuals across the LHIN – Fund Bethell House operated by Hospice Caledon – Implement a palliative care strategy within the Central West LHIN regional cancer program – Establish palliative outreach team for LTC facilities – Establish protocols to respond to ethno-cultural needs with respect to palliative / end of life care and ensure residents are aware of them	– Increased access and use of palliative / end-of-life services by local residents and caregivers based on need and preference
Rehabilitation	– Develop integrated regional rehabilitation program across hospitals and CCAC based on best practices – Decrease high ALC bed numbers associated with rehabilitation requirements – Increase number of rehabilitation beds dedicated to low intensity, long duration needs – Convert Complex Continuing Care beds to Rehabilitation beds at Headwaters Health Care Centre	– Increased number of Rehabilitation beds – Development of Low Intensity Longer Term Rehabilitation beds
Services for Seniors	– Implement the 3rd year of Aging at Home initiatives to reduce ER wait times and the number of Alternative Level of Care days – Implement a "seniors-friendly" hospital system – Implement an integrated Regional Geriatric Service across the LHIN – Develop a LHIN wide "falls prevention program" based on best practices – Expand outreach teams to LTC facilities and Assisted Living homes – Expand Telecheck – Expand the number of supportive living units – Establish an integrated transportation system for seniors – Develop a diabetes strategy for seniors – Establish integrated services teams for high risk seniors – Detail wound management programs in accountability agreements	– Reduce emergency wait times for seniors – Increased number of highly complex, frail seniors receiving case management / care coordination in the community – Reduced wait time to LTC home placements from hospital and the community

Key Priorities	Actions	Performance Measures
Services for Women and Children	– Implement recommendations from provincial task forces and strategies focused on women and child issues into local action (e.g., Provincial Council for Children's Health, Maternal Newborn Advisory Committee, Provincial Paediatric Wait Time Strategy, Maternal-Newborn Access to Care Strategy) to be applied to the Central West LHIN – Establish child friendly hospitals and enhance child and family centred care – Create a regional integrated obstetrical service between HHCC and WOHS – Increase NICU bed capacity – Establish implementation plans for integrated services for the identified clinical priorities of the Maternal Child Core Action Group o Antenatal services o Breastfeeding o Obesity o Speech and languages services o Maternal mental health o Medically complex / fragile children – Partner in regional Gynaecologic Oncology program – Develop the role of Community Health Centres in women and children's services – Create a paediatric specific pod in the Emergency Department	– Reduction in the caesarean section rate – Reduction in the number of low birth weight newborns – Increase in self-reported breast-feeding by new mothers – Reduction in child injury hospitalizations – Reduction in children and youth obesity rates
Diversity and Equity **We have a vision for a health system that values ethno-cultural diversity and works to improve access for all residents of the Central West LHIN to culturally competent health care services.**	▪ Align strategies to meet the needs of the diverse ethno-cultural population ▪ Include a requirement for the development of a Health Equity Plan as part of each health service provider's accountability agreement ▪ Continue research with York University's Institute for Health Research on issues of health and ethno-cultural diversity	***Key outcome will be demonstrated when access to care mirrors the profile of the local population, including:*** ▪ Increase in the number of culturally competent health services available that are designed to meet the specific needs of the LHIN's diverse communities
Health Human Resources **We have a vision of expanded inter-professional collaboration and education, and an increase in the number of health human resources in the LHIN that reflect the needs and diversity of the LHIN communities.**	▪ Continue to work with the HealthForceOntario partnership Coordinator in order to recruit physicians to our LHIN ▪ Enhance education and inter-professional collaboration among health care providers by establishing the Central West LHIN Inter-professional Collaboration and Education Action Group ▪ Enhance community health and preventative strategies and align human resources to support the strategy ▪ Continue to submit proposals to HealthForceOntario for Family Health Teams and Nurse Practitioner clinics ▪ Develop local plans for enhancing the role of informal care-givers based on provincial strategies	***Key outcome will be an increase in the availability of health professionals for local residents, including:*** ▪ Within the LHIN, higher per capita rates for health professionals ▪ Increased number of inter-professional collaborations and working arrangements

Key Priorities	Actions	Performance Measures
	▪ Continue to review leading practices for volunteer recruitment and scope of work ▪ Review and consider the role of Midwives, Registered Practical Nurses, Physician Assistants, Personal Support Workers, and other allied health professionals to address health human resource shortages ▪ Require health service provider organizations to develop a Health Human Resources plan ▪ Support the Health Professionals Advisory Committee to act on recommendations with respect to Health Human Resources planning ▪ Develop good governance across the LHIN, including: o Holding on-going dialogue with health service provider Board members o Developing governance orientation and training o Maintaining the governance portal	
Back Office Services **We have a vision of administrative and support services focused on effectiveness and efficiency by improving value, service quality, risk management and business controls.**	▪ Action the Back Office Integration Options and Directions report recommendations, such as: o Establish a Back Office Integration Council / Committee o Develop an inventory of integration and collaboration initiatives o Establish a working group to review OntarioBuys supply chain management performance metrics and establish a baseline suitable for Central West LHIN providers o Develop a centralized and online product, services and supplies marketplace ▪ Develop a referral management system ▪ Bring Shared Services West into actions	***Key outcome will be enhanced capacity within back office functions, including:*** ▪ High rates of membership or use of group purchasing initiatives by health service providers ▪ Increased number of collaborations among health service providers that enhance capacity within back office functions.

8. Summary

The Integrated Health Services Plan is about action. The Central West LHIN is proud to establish its second Integrated Health Services Plan which provides the community with definite actions that the LHIN will undertake to improve access to integrated, high quality health services over the next three years.

This 30 page document highlights the Central West LHIN's vision for the local health system and the priorities and strategic directions for the local health system. It lists specific actions and their rationale. The IHSP2 document indicates how the LHIN, along with health service providers, will demonstrate their impact on improving the delivery of health care to the community and the health of the residents of the LHIN.

Over the next three years, the IHSP2 integration priorities will be reviewed and refined on a regular basis to ensure the needs of those that receive health care, and those that deliver it, are met. We will seek the ongoing input from our health care partners and the residents of the Central West LHIN to inform this work. It's about you and your health!